



Department of Medical Assistance Services  
600 East Broad Street, Suite 1300  
Richmond, Virginia 23219  
<http://www.dmas.state.va.us>

# MEDICAID MEMO

TO: Medicaid Enrolled Providers of Respite Services for the Elderly or Disabled with Consumer Direction Waiver and Technology Assisted Waiver

FROM: Cynthia B. Jones, Director  
Department of Medical Assistance Services (DMAS)

MEMO: Special

DATE: 3/4/2014

SUBJECT: Respite Care Service Authorizations — *Changes Effective March 1, 2014*

The purpose of this memorandum is to notify providers of two (2) respite care changes under the Elderly or Disabled with Consumer Direction (EDCD) Waiver and the Technology Assisted Waiver (TW). For clarification purposes, the memorandum also includes information on respite care related processes that are not impacted by these changes. *Information regarding respite changes for Intellectual Disabilities (ID) and Individual and Family Developmental Disabilities (DD) Waivers is forthcoming in a subsequent memorandum.*

## **1. Duration Changes for EDCD and TW Respite Authorizations**

Effective March 1, 2014, the Department of Medical Assistance Services (DMAS) is changing the duration for respite care authorizations to 24 months (previously 12 months) for new respite *admissions, re-admissions, and transfer requests* for both EDCD and TW. The respite care 24-month duration change will also apply to EDCD and TW renewals beginning in 2015.

### **➤ New Respite Admissions, Re-admissions, and Transfer Requests for EDCD and TW**

Providers must continue to submit requests to KEPRO for new respite admissions, re-admissions and transfers. Effective March 1, 2014 providers submitting requests for new respite admissions, readmissions and transfers to KEPRO must include the end date for 24-month duration. KEPRO will review the request and make a final determination for 24-month duration. Reviews conducted by KEPRO will produce the normal courtesy letter generated from KEPRO to the provider, as well as the DMAS generated letter that is the authorization to bill. Requests must be submitted within 10 business days of the start of care. Timeliness rules apply.

### **➤ Future Respite Renewals Ending in 2015 for EDCD and TW**

Providers may submit a request for continuation of EDCD and TW respite service authorizations that end in 2015 (or beyond) within one month prior to the expiration of the current service authorization (where the member's unpaid primary caregiver continues to need respite services).

## **2. New End Dates for EDCD Respite Renewal Authorizations Ending May 2014 through December 2014**

DMAS will identify and automatically change the existing respite authorization end dates for EDCD waiver that currently end on or after May 1, 2014, to disperse the respite renewal dates more evenly across the calendar months, and to prevent a large volume of respite renewals due at the start of the state fiscal year. This change

applies to EDCD agency directed (RESPI) and EDCD consumer directed (S5150) respite services. These respite authorizations will be automatically extended to the member's birth month, birth day, and year 2015, without providers having to submit a request. Providers and members will receive a DMAS generated letter with the new respite end date of 2015; this is the provider's authorization to bill. This automatic generation of the new respite end date will not produce the normal courtesy letter from KEPRO to the provider. *This will be a one-time automatic respite extension to move respite renewals off the state fiscal year.*

#### **Other EDCD and TW Respite Renewals Ending in 2014 Will Not Change**

The process for EDCD renewals with end dates prior to May 2014 will not change. Additionally, TW respite service authorizations expiring in 2014 will continue to follow the existing process.

- **Renewal Process for EDCD Authorizations Ending January 2014 through April 2014**  
Providers may submit a request for continuation of respite services for EDCD respite authorizations that end January 2014 through April 2014 within one month prior to the expiration of the current service authorization, where the member's unpaid primary caregiver continues to need respite services. These will be renewed as they normally are, extending the authorization 12 months from the current authorization end date. KEPRO will review the request and make a final determination. Providers will receive a courtesy letter from KEPRO with the final determination, as well as the DMAS generated letter for billing. Timeliness rules will apply. *Requests submitted during this time frame will be authorized for 12-month duration.*
- **Renewal Process for Technology Assisted Waiver (TW) respite authorizations ending in 2014**  
Technology Assisted Waiver respite (RESPI) authorization end dates will not be auto-extended, as they are currently distributed evenly across the calendar months. Providers may submit a request for continuation of respite services for TW respite authorizations ending in 2014 within one month prior to the expiration of the current service authorization. KEPRO will renew TW respite (RESPI) requests ending in 2014 for 12-month duration. DMAS will renew all other respite for 12- month duration.

#### **Annual Service Limitation for EDCD and TW Respite Will Not Change**

Regardless of the dates authorized for respite services, the annual service limit for EDCD respite will remain at 480 units per fiscal year (July 1 through June 30) for EDCD waiver, whether using agency directed, consumer directed, or a combination of both, and 360 units per calendar year (January 1 through December 31) for Technology Assisted waiver.

#### **Optional Alignment of Services for EDCD Waiver – Effective July 1, 2014**

DMAS will allow providers the option of aligning the respite (RESPI and S5150) with the personal care (T1019 and S5126) renewal date. This option is available to those providers who provide *both* respite and personal care to the individual.

For personal care renewals due on or after July 1, 2014 providers may choose to align the respite care end date with the existing personal care end date. If the provider submits the request through Atrezzo, information on aligning the respite care end dates must be included in the "Additional Information" section. The DMAS-98 has been revised to include a check box for "Alignment" at the top, and instructions for the provider. A copy of the revised DMAS-98, with the instructions is attached to this memo. Providers who submit requests for alignment prior to July 1, 2014 will have the request rejected and may resubmit on or after July 1, 2014.

If the provider chooses to align the respite end date to the personal care end date, the alignment request must include the case ID numbers for both respite and personal care. If the current respite authorization ends prior to the personal care end date a *new* request must be submitted for respite to extend the end date to align with the personal care end date. If the provider requests alignment and the respite end date is past the current authorized personal care end dates there is the potential that the authorized respite end date will be cut back to match the authorized personal care end date.

### **Provider Training for EDCD Respite Extension and Alignment of Respite to Personal Care**

DMAS will host two (2) webinars for EDCD providers to clarify the changes and address provider questions.

➤ **New End Dates for Authorizations Ending May through December, 2014**

The first webinar is scheduled for April 10<sup>th</sup> from 10am-12 noon. This webinar will explain how the EDCD respite authorizations will be extended to the birth month, day, and year 2015. Examples will be provided in the webinar. You may register for this training session at the following URL address: <https://dmas.webex.com/dmas/k2/j.php?MTID=tc7cf2bd34b5d0f38f1d364ff3bae0f58>.

➤ **Optional Alignment of Respite with Personal Care Authorizations**

The second webinar is scheduled for May 20<sup>th</sup> from 10 am-11:30 am and will explain to EDCD waiver providers how to request alignment of respite authorized dates to the personal care authorized dates and the documentation necessary for submitting the alignment request to KEPRO. Examples will be provided in this webinar. You may register for this training session at the following URL address: <https://dmas.webex.com/dmas/k2/j.php?MTID=t3b8360bd0e7bef76ee1fa018920d3387>.

*Upon completion of the webinar registration, registered providers should receive a confirmation email with all of the training details and instructions. The number of participants allowed in each session is limited. Once a session is full, additional registration requests will be waitlisted. Waitlisted providers will be registered if a confirmed participant cancels. If you do not receive the confirmation email or if you have any questions regarding these sessions, please call 804-225-4578. If you have any problems logging in on the day of the session please call 1-866-229-3239.*

KEPRO will also host a training session on the EDCD respite to personal care alignment process. This training will take place on June 3, 2014 from 11am-12noon. You can log into this live webinar by entering the following URL address into your browser <http://kepro.adobeconnect.com/r8ucvx19qtm/> No registration is required. The provider will need to enter their name then click on "Enter Room". There is no limit to the amount of attendees. For any providers unable to attend the live webinar, training slides will be available on KEPRO's website as of June 4, 2014 to review at <http://dmas.kepro.com/content/training.aspx> and click on the Waiver tab.

### **Methods of Submission to KEPRO**

All submission methods and procedures are fully compliant with the Health Insurance Portability and Accountability Act (HIPAA) and applicable federal and state privacy and security laws and regulations. Providers will not be charged for submission, via any media type, for service authorization requests submitted to KEPRO. KEPRO accepts service authorization (srv auth) requests through direct data entry (DDE), fax and phone.

Submitting through Direct Data Entry (DDE) places the request in the worker queue immediately. For DDE, providers must use Atrezzo Connect Provider Portal. For DDE, service authorization checklists may be

accessed on KEPRO's website to assist in assuring specific information is included with each request. To access Atrezzo Connect on KEPRO's website, go to <http://dmas.kepro.com>. Faxes are entered by staff in the order received.

Provider registration is required to use Atrezzo Connect. The registration process for providers is immediate on-line. From <http://dmas.kepro.com>, providers not already registered with Atrezzo Connect may click on "Register" to be prompted through the registration process. Newly registering providers will need their 10-digit National Provider Identification (NPI) number and their most recent remittance advice date for YTD 1099 amount. The Atrezzo Connect User Guide is available at <http://dmas.kepro.com>: Click on the *Training* tab, then the *General* tab.

Providers with questions about KEPRO's Atrezzo Connect Provider Portal may contact KEPRO by email at [atrezzoissues@kepro.com](mailto:atrezzoissues@kepro.com). For service authorization questions, providers may contact KEPRO at [providerissues@kepro.com](mailto:providerissues@kepro.com). KEPRO may also be reached by phone at 1-888-827-2884, or via fax at 1-877-OKBYFAX or 1-877-652-9329.

#### **MANAGED CARE ORGANIZATIONS**

Many Medicaid recipients are enrolled with one of the Department's contracted Managed Care Organizations (MCO). In order to be reimbursed for services provided to an MCO enrolled individual, providers must follow their respective contract with the MCO. The MCO may utilize different prior authorization, billing, and reimbursement guidelines than those described for Medicaid fee-for-service individuals. For more information, please contact the MCO directly. Additional information about the Medicaid MCO program can be found at [http://www.dmas.virginia.gov/Content\\_pgs/mc-home.aspx](http://www.dmas.virginia.gov/Content_pgs/mc-home.aspx).

#### **COMMONWEALTH COORDINATED CARE**

Commonwealth Coordinated Care (CCC) is a new initiative to coordinate care for individuals who are currently served by both Medicare and Medicaid and meet certain eligibility requirements. Please visit the website at [http://www.dmas.virginia.gov/Content\\_pgs/altc-home.aspx](http://www.dmas.virginia.gov/Content_pgs/altc-home.aspx) to learn more.

#### **VIRGINIA MEDICAID WEB PORTAL**

DMAS offers a web-based Internet option to access information regarding Medicaid or FAMIS member eligibility, claims status, check status, service limits, service authorizations, and electronic copies of remittance advices. Providers must register through the Virginia Medicaid Web Portal in order to access this information. The Virginia Medicaid Web Portal can be accessed by going to: [www.virginiamedicaid.dmas.virginia.gov](http://www.virginiamedicaid.dmas.virginia.gov). If you have any questions regarding the Virginia Medicaid Web Portal, please contact the Xerox State Healthcare Web Portal Support Helpdesk, toll free, at 1-866-352-0496 from 8:00 a.m. to 5:00 p.m. Monday through Friday, except holidays. The MediCall audio response system provides similar information and can be accessed by calling 1-800-884-9730 or 1-800-772-9996. Both options are available at no cost to the provider. Providers may also access service authorization information including status via KEPRO's Provider Portal at <http://dmas.kepro.com>.

#### **"HELPLINE"**

The "HELPLINE" is available to answer questions Monday through Friday from 8:00 a.m. to 5:00 p.m., except on holidays. The "HELPLINE" numbers are:

1-804-786-6273	Richmond area and out-of-state long distance
1-800-552-8627	All other areas (in-state, toll-free long distance)

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Please remember that the “HELPLINE” is for provider use only. Please have your Medicaid Provider Identification Number available when you call.

**Attached Number of Pages: (16)**



## Community Based Care Request for Services Form

**Confidential**

<b>KePRO/DMAS now require any Medicaid Provider submitting Service Authorization using their National Provider Identifier (NPI) or Atypical Provider Identifier (API) to provide their 9-digit zip code. If you do not know your <u>9-digit zip code</u>, then please visit: <a href="http://zip4.usps.com/zip4/welcome.jsp">http://zip4.usps.com/zip4/welcome.jsp</a>. Please see instructions per service type.</b>												
<b>Fax: 1-877-OKBYFAX (877-652-9329)</b>			<b>Phone: 1-888-827-2884</b>									
<b>1. <input type="checkbox"/> New Request</b>	<input type="checkbox"/> Change SRV AUTH#	<input type="checkbox"/> Cancel SRV AUTH#	<input type="checkbox"/> Transfer	<input type="checkbox"/> Respite alignment request with personal care (EDCD only)								
<b>2. Date of Request</b>  (mm/dd/yyyy)  / /	<b>3. Review Type: (Please Check One)</b> <input type="checkbox"/> Waiver Enrollment <input type="checkbox"/> Waiver Enrollment-Retrospective Review (Date Notified of Eligibility) / / <input type="checkbox"/> Service Request-If a Retrospective Review (Date Notified of Eligibility) / /											
<b>4. Member Medicaid ID Number:</b>  ID Number (12 digits)	<b>5. Member Last Name:</b>  	<b>6. Member First Name:</b>  	<b>7. <input type="checkbox"/> Date of Birth</b>  (mm/dd/yyyy)  / /	<b>8. Gender</b> <input type="checkbox"/> Male <input type="checkbox"/> Female								
<b>9.</b> <b>a. Service Provider Name:</b>  <b>b. NPI/API Provider ID Number:</b>  <b>c. 9 digit zip code: (required)</b>		<b>10. Primary Diagnosis Code/Description:</b> <b>a.</b>  <b>b.</b>  <b>c.</b>										
<b>11.</b> <b>a. NPI/API Submitting Provider/Case Manager for DD Waiver / Transition Coordinator (for EDCD Waiver only). Name and Provider ID Number:</b>  <b>b. 9 digit zip code: (required)</b>		<b>12. SRV AUTH Service Type:</b> <table style="width: 100%; border: none;"> <tr> <td style="border: none;"><input type="checkbox"/> 0900-EDCD Waiver</td> <td style="border: none;"><input type="checkbox"/> 0090-EPSDT Private Duty Nursing</td> </tr> <tr> <td style="border: none;"><input type="checkbox"/> 0902- DD Waiver</td> <td style="border: none;"><input type="checkbox"/> 0091-EPSDT Personal/Attendant Care</td> </tr> <tr> <td style="border: none;"><input type="checkbox"/> 0909-MFP</td> <td style="border: none;"><input type="checkbox"/> 0098-EPSDT Private Duty Nursing in School-MCO</td> </tr> <tr> <td style="border: none;"><input type="checkbox"/> 0960-Technology Waiver</td> <td style="border: none;"></td> </tr> </table>			<input type="checkbox"/> 0900-EDCD Waiver	<input type="checkbox"/> 0090-EPSDT Private Duty Nursing	<input type="checkbox"/> 0902- DD Waiver	<input type="checkbox"/> 0091-EPSDT Personal/Attendant Care	<input type="checkbox"/> 0909-MFP	<input type="checkbox"/> 0098-EPSDT Private Duty Nursing in School-MCO	<input type="checkbox"/> 0960-Technology Waiver	
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<input type="checkbox"/> 0909-MFP	<input type="checkbox"/> 0098-EPSDT Private Duty Nursing in School-MCO											
<input type="checkbox"/> 0960-Technology Waiver												
<b>13. Justification/Need for Waiver Service Requested:</b>   												
<b>14. Additional Comments (See instructions pertaining to each procedure code):</b>   												

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## Community Based Care Request for Services Form

**Confidential**

Each service being requested must list each procedure code separately on this form.

<b>Member Last Name:</b>		<b>Member First Name:</b>				<b>Member Medicaid ID Number:</b>		
15. Procedure Code (National Code):	16. Narrative Description:	17. Modifiers (If Applicable)	18. Units/Hours Requested	19. Frequency	20. Actual Cost per Unit (if applicable)	21. Total Dollar Requested (if applicable)	22. Dates of Service	
							From (mm/dd/yyyy)	Thru (mm/dd/yyyy)
							/ /	/ /
							/ /	/ /
							/ /	/ /
							/ /	/ /
							/ /	/ /
<b>23. Contact Person:</b>		<b>24. Contact Phone Number:</b>				<b>25. Contact Fax Number:</b>		

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## Community Based Care Request for Services Form

<b>Member Last Name:</b>	<b>Member First Name:</b>	<b>Member Medicaid ID #:</b>
<b>Is this request for EPSDT Personal Care in the school setting?</b> <input type="checkbox"/> Yes <input type="checkbox"/> No (If Yes, Please answer school related questions below)		
<b><u>EPSDT Specialized Services Request:</u></b>		
1. What nursing services are being requested (LPN, RN, or both)?		
2. What is the members benefit Plan (MCO, FFS, Other)?		
3. What time of the day will the services routinely be delivered?		
4. Is there a sibling in the home who receives Medicaid-funded services? <span style="float: right;">If yes, name &amp; Medicaid number of sibling (s)</span>		
5. Is this a congregate nursing request?		
6. Please describe the services being provided to both children.		
7. List the agencies who provide the care: <input type="checkbox"/> Yes <input type="checkbox"/> No		
8. Assessment Hours provided (New cases only):		
9. Assessment Dates:		
<b><u>School Services Request for 0091, 0090, 0098: EPSDT MCO School Carve Out:</u></b>		
1. What is the name of the MCO?		
2. Is the service part of the child's Individualized Education Plan (IEP)? <input type="checkbox"/> Yes <input type="checkbox"/> No		
3. School Division Name/School Name:		
<b><u>Tech Waiver Skilled Respite Request:</u></b>		
1. Is the member currently receiving Tech Waiver Private Duty Nursing <input type="checkbox"/> Yes <input type="checkbox"/> No		
2. What is the authorization number?		
3. What is the service authorization start date?		
4. What is the name of the unpaid primary caregiver?		
5. Backup plan?		
6. Will the service be provided in the member's primary residence?		
7. Have Health, Safety, and Welfare (HSW) issues been identified with this member? If yes, please explain and detail an action(s) taken to address HSW issues.		
8. Has APS/CPS referral been made? If no, when will APS/CPS be notified?		





## Community Based Care Request for Services Form

### INSTRUCTIONS FOR WAIVER AND EPSDT ELECTRONIC FAX FORM

**Web Resources:** <http://dmas.kepro.com/>  
[www.dmas.virginia.gov](http://www.dmas.virginia.gov)

This FAX submission form is required for Waiver and EPSDT enrollment and service requests for Service Authorization (SRV AUTH) review. SRV AUTH requests may be submitted via Phone, Fax, U.S. Mail or DDE.

Please be certain that all information blocks contain the requested information. Incomplete information may result in the case being rejected or returned via FAX for additional information. For EDCD Waiver enrollment requests only, send pertinent documents needed for enrollment.

If KePRO determines that this request meets appropriate review guidelines the request will be “tentatively approved” and transmitted to DMAS Fiscal Agent for the final approval. Final approval is contingent upon passing remaining Member and Provider eligibility/enrollment edits. The Service Authorization (SRV AUTH) number provided by the DMAS Fiscal Agent will be sent to you through the normal letter notification process and will be available to all Providers registered with the web-based program Atrezzo Connect™ (<http://dmas.kepro.com/>) within 24 hours (or the next business day) if reviewed, approved, and transmitted to DMAS’ Fiscal Agent prior to 5:30 PM of that day.

1. **Request type:** Place a ✓ or X in the appropriate box.

- **New:** Use for all new requests. Resubmitting a request after receiving a reject is also considered a new request.
- **Change:** Use to make a change to a previously approved request; the provider may change the quantity of units, dollar amount approved, or dates of service due to changes in delivery or rescheduling and appointment. If additional units are requested for the same dates of service, enter the total number of units needed and not the increased amount. Any change request for increased services must include appropriate justification, including information regarding new physician orders when required. **When a provider discontinues services, this is submitted as a change.** The provider may not submit a “change” request for any item that has been denied or is pending. Include the SRV AUTH number you wish to change.
- **Cancel:** Use only to cancel all or some of the items under one service authorization number. Do not use for a discharge or discontinuance of services. An example of canceling all lines is when an authorization is requested under the wrong Member or Provider number. Include the SRV AUTH number to be cancelled.
- **Transfer:** Use for requesting a transfer of care or transfer of a provider number.
- **Alignment:** *For EDCD Waiver Alignment Only.* Use to request alignment of respite care services with personal care services. Request must include the case ID numbers for both respite and personal care; this information can be documented using



### Community Based Care Request for Services Form

the additional comments section at the bottom of page 1. **If the current respite authorization ends prior to the personal care end date, a new request must be submitted for respite in order to align the two services.** Along with checking this box you must also complete page 2 of the request form and completely fill out all requested information to include: procedure code, narrative description and to and from dates.

2. **Date of Request:** Request in MM/DD/YYYY format.
3. **Review Type:** Place a ✓ or X in the appropriate box. For retrospective Medicaid eligibility or if the request is not submitted within 10 business days of the Start of Care, state the date the Provider received verification of Medicaid eligibility (DMAS-225). The date the DMAS-225 is received is not required unless submitting a request more than 10 business days after the Start of Care and retroactive Medicaid eligibility authorization is requested.
4. **Member Medicaid ID Number:** It is the Provider's responsibility to ensure the Member's Medicaid number is valid prior to initiating this request. This is a 12 digit number.
5. **Member Last Name:** Enter the Member's last name exactly as it appears on the Medicaid card.
6. **Member First Name:** Enter the Member's first name exactly as it appears on the Medicaid card.
7. **Date of Birth:** Must be in the MM/DD/YYYY format (for example, 02/25/2004).
8. **Gender:** Please place a ✓ or X to indicate the gender of the Member.
9.
  - a. **NPI/API Service Provider Name and Provider ID Number:** Enter the name of the Provider who is providing the service and Provider ID number or National Provider Identifier (when the NPI is issued).
  - b. **9 digit Zip Code (Required):** Providers must enter their 9 digit zip code to ensure their correct location is identified for the NPI number being submitted.
10. **Primary Diagnosis Code/Description: This is a required field.** Provide the primary diagnosis code and/or description indicating the reason for service(s). You can enter up to 5 ICD-9 codes and / or diagnostic descriptions.
11.
  - a. **NPI/API Submitting Provider/Case Manager (For DD Waiver) /Transition Coordinator (For EDCD Waiver) Name and Provider ID Number:** Enter the submitting Provider name and Provider ID number, National Provider Identifier or Atypical Provider Identifier for the Provider submitting the request.
  - b. **9 digit Zip Code (Required):** Providers must enter their 9 digit zip code to ensure the correct location is identified for the NPI/API number being submitted.
12. **SRV AUTH Service Type:** Place a ✓ or X to indicate the category of service being requested.
13. **Justification/Need for Requested Waiver Service:** Knowledge of the DMAS criteria/guidelines are required to provide pertinent information. Refer to the service being requested and include the necessary information.



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14. **Additional Comments:** Used for further information and other considerations and circumstances to justify the request for medical necessity or the number of services. Describe expected prognosis or functional outcome. List additional information for each item to meet the criteria in the regulations, DMAS manual, and criteria (see Chapter IV and SRV AUTH Appendices in the DMAS manual).



## Community Based Care Request for Services Form

### TABLE OF CODES WITH NARRATIVE:

National Code /Modifier	Service Category/Description	Waiver
97139	<b>Therapeutic Consultation:</b> Justification/Need must include name of at least one other qualifying service currently authorized under the Waiver. Justification/Need may NOT include direct therapy, nor duplicate activities available through the State Plan. Justification/Need cannot be solely for the purpose of monitoring. <ul style="list-style-type: none"> <li>Service must be approved on the DMAS DD POC.</li> </ul>	DD
97537	<b>Day Support, Regular, Center or Non-Center Based:</b> <ul style="list-style-type: none"> <li>Service must be approved on the DMAS DD POC.</li> </ul>	DD
97537 U1	<b>Day Support – High Intensity Center or Non-Center Based:</b> <ul style="list-style-type: none"> <li>Service must be approved on the DMAS DD POC.</li> </ul>	DD
H0040	<b>Crisis Stabilization – Supervision:</b> Justification/Need must include name of at least one other qualifying service currently authorized under the Waiver. <ul style="list-style-type: none"> <li>Service must be approved on the DMAS DD POC.</li> <li>There is a 15 day limit per authorization.</li> </ul>	DD
H2011	<b>Crisis Stabilization- Intervention:</b> See code H0040 of this table. Must be approved on DMAS POC under 0902. <ul style="list-style-type: none"> <li>Service must be approved on the DMAS DD POC.</li> </ul>	DD
H2014	<b>In-home Residential Support:</b> Justification/Need must include documentation of the name of the In-Home Residential Support direct care staff and the relationship to the Member. This is not the name of Provider agency. <ul style="list-style-type: none"> <li>Service must be approved on the DMAS DD POC.</li> </ul>	DD



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National Code /Modifier	Service Category/Description	Waiver
H2021 TD	<p><b>PERS Nursing – RN:</b>  <b>DD Waiver:</b>            Justification/Need must include documentation that the Member is authorized for PERS and medication monitoring (S5185).            Justification/ Need must include documentation of the physician name and date for the physician ordered medication monitoring units and the name of at least one other qualifying Waiver service being provided.</p> <ul style="list-style-type: none"> <li>• Service must be approved on DMAS DD POC.</li> </ul> <p><b>EDCD Waivers:</b>            Justification/Need must include documentation that the individuals receiving PERS does not receive supervision on the personal care POC.            Justification/Need must include documentation of the members’ cognitive level.            Justification/Need must include documentation of the members living alone or is alone for significant parts of the day and has no regular caregiver for extended periods of time.            Justification /Need must include documentation of the physician name and date for the physician ordered medication monitoring units and the name of at least one other waiver qualifying service being provided.</p>	DD, EDCD
H2021 TE	<p><b>PERS Nursing – LPN:</b>  <b>DD Waiver:</b>            Justification/Need must include documentation that the Member is authorized for PERS and medication monitoring (S5185).            Justification/ Need must include documentation of the name and date of the physician ordered medication monitoring units and the name of at least one other qualifying Waiver service being provided.</p> <ul style="list-style-type: none"> <li>• Service must be approved on DMAS DD POC.</li> </ul> <p><b>EDCD Waivers:</b>            Justification/Need must include documentation that the individuals receiving PERS does not receive supervision on the personal care POC.            Justification/Need must include provider documentation of the members’ cognitive level.            Justification/Need must include documentation of the members living alone or is alone for significant parts of the day and has no regular caregiver for extended periods of time.            Justification/Need must include documentation of the physicians name and date for physician ordered medication monitoring units and the name of at least one other qualifying Waiver service being provided.</p>	DD, EDCD
H2023	<p><b>Supported Employment-Individual:</b>  <u>Individual Supported Employment:</u> Provided by a one to one job coach in order to work independently.</p> <ul style="list-style-type: none"> <li>• Service must be approved on the DMAS DD POC.</li> </ul> <p><b>NOTE: This service, either as a standalone service or in combination with Prevocational and or Day Support services <u>shall be limited to 2080 units per POC year.</u></b></p>	DD



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National Code /Modifier	Service Category/Description	Waiver
H2024	<p><b><u>Supported Employment – Enclave (Group):</u></b> Continuous support provided by staff to eight or fewer individuals in an enclave, work crew or bench/ entrepreneurial model.</p> <ul style="list-style-type: none"> <li>Service must be authorized on DMAS DD POC.</li> </ul> <p><b>NOTE: This service, either as a standalone service or in combination with Prevocational and or Day Support services <u>shall be limited to 780 units per POC year.</u></b></p>	DD
H2025	<p><b>Pre-Vocational Services, Regular Intensity:</b> Justification/ Need must include documentation of the date, type of services rendered and the number of hours and units provided per week.</p> <ul style="list-style-type: none"> <li>Service must be authorized on DMAS DD POC.</li> </ul> <p><b>NOTE- This service, either as a stand- alone service or in combination with Supported Employment <u>services shall be limited to 780 units per POC year.</u></b></p>	DD
H2025 U1	<p><b>Pre-Vocational Services, High Intensity</b> See Code H2025 in this table.</p>	DD
S5102	<p><b>Adult Day Health Care:</b> Justification/ Need must include documentation of the number of days per week and hours of ADHC services, as well as the date the DMAS 301 was signed and dated.</p>	EDCD
S5111	<p><b>Family Caregiver Training:</b> Justification/ Need must include the name and title of the professional providing the training. Justification/ Need must include documentation of the name of at least one other qualifying IFDDS Waiver service and the name of the individual being trained and the relationship to the Member.</p> <ul style="list-style-type: none"> <li>Service must be approved on DMAS DD POC.</li> </ul>	DD
S5126	<p><b>CD Personal Care CD/Personal Assistance:</b></p> <p><b>EDCD Waiver</b> Justification / Need must include documentation of the member’s mental/cognitive status and name of emergency backup person. The Member’s LOC from the DMAS 97 A/B (if LOC C, the skilled nursing need must be documented, the type of services needed and the time of day it is provided, the total number of weekly hours requested where the services are performed and the first day the aide provided hands on care. The number of hours of Supervision, documentation of the Member’s mental/cognitive status, ability to use the phone, no one present in the home to call for help and why it is needed. The name of the person directing the care and the name of the person providing the care. Who is with the member at all times when the aide is not present? The name of the Service Facilitator.</p>	EDCD, DD



## Community Based Care Request for Services Form

National Code /Modifier	Service Category/Description	Waiver
S5126	<p><b>DD Waiver</b> Justification/Need must include documentation of the name of the attendant and the relationship to the Member; as well as the name of the individual directing the care.</p> <ul style="list-style-type: none"> <li>• Service must be approved on the DMAS DD POC.</li> </ul> <p><u>For readmissions post discharge or transfer to a new Provider:</u> A new assessment (DMAS 99) must be included in the documentation. If there is an increase or decrease in the amount of hours from the previous authorization/Provider, information from a new Plan of Care (DMAS 97 A/B) and justification for the change in hours is required for review.</p>	EDCD, DD, EPSDT PC/AC
	<p><b>NOTE: Training is not PC services.</b></p> <p><b>NOTE: All waivers-aides may not be parents of minor children who are receiving Waiver services or the spouse of the individuals who are receiving Waiver services or the family/caregivers that are directing the individual's care.</b></p>	
S5135	<p><b>Companion Care (CC):</b></p> <p><b>NOTE: CC is not authorized for persons whose only need for CC is for assistance exiting the home in the event of an emergency and/ or socialization. CC is limited to 2080 hours per POC year for both types of CC combined.</b></p> <ul style="list-style-type: none"> <li>• Service must be approved on the DMAS DD POC.</li> </ul>	DD
S5136	<p><b>CD-Companion Care:</b> See code S5135 in this table above.</p> <ul style="list-style-type: none"> <li>• Service must be approved on the DMAS DD POC.</li> </ul>	DD
S5150	<p><b>Consumer-Directed Respite Services:</b></p> <p><b>DD Waiver:</b> <u>For readmissions after discharge or transfer to a new provider:</u> A new assessment (DMAS 99) must be included in the documentation.</p> <ul style="list-style-type: none"> <li>• Service must be approved on the DMAS DD POC.</li> </ul> <p>Justification/Need must include the name of the unpaid PCG, the name of the individual directing the care and name of paid attendant.</p> <p><b>EDCD Waiver:</b> Justification/Need must include documentation of the name of the <b>unpaid</b> PCG, the name of individual directing the care and name of the paid attendant, name of the emergency back-up person and where the care is provided.</p>	EDCD, DD



## Community Based Care Request for Services Form

National Code /Modifier	Service Category/Description	Waiver
S5160	<p><b>PERS Installation:</b>  <b>DD and EDCD Waiver:</b> Must be requested with S5161.            For DD only: Service must be approved on the DMAS DD POC.            Justification/Need must include name of at least one qualifying service currently authorized under the Waiver.</p> <ul style="list-style-type: none"> <li>Service must be approved on the DMAS DD POC.</li> </ul>	DD, EDCD
S5160 U1	<p><b>PERS Medication Monitoring Installation:</b> Must be requested with S5185.</p> <ul style="list-style-type: none"> <li>See S5160 in this table above.</li> <li>For DD only: Service must be approved on the DMAS DD POC.</li> </ul>	EDCD, DD
S5161	<p><b>PERS Monitoring:</b></p> <p><b>DD Waiver:</b>            If submitted without PERS install, there must be PERS install authorization in place or documentation must include verification that member has PERS unit in place (e.g. through private pay).            Justification/Need must include name of at least one qualifying service currently authorized under the Waiver.</p> <ul style="list-style-type: none"> <li>Service must be approved on the DMAS DD POC.</li> </ul> <p><b>DD and EDCD Waiver:</b> Must be requested with S5161.            Justification/Need must include name of at least one qualifying service currently authorized under the waiver.</p> <ul style="list-style-type: none"> <li>Service must be approved on the DMAS DD POC.</li> </ul> <p><b>EDCD Waiver:</b>            Justification/Need must include documentation of prior- installation of a PERS system or current request of installation, the name of at least one other billable Waiver service, documentation that the individuals receiving PERS does not receive Supervision on the personal care POC.            Justification/Need must include Provider documentation of the Members' cognitive level.            Justification/Need must include Provider documentation of the Members living alone or is alone for significant parts of the day and has no regular caregiver for extended periods of time.</p>	EDCD, DD





## Community Based Care Request for Services Form

National Code /Modifier	Service Category/Description	Waiver
S5165	<b>Environmental Modifications-</b>  <b>DD Waiver:</b> Any request, change, increase, decrease and/or update must be pre-approved by DMAS on the POC before Service Authorization can occur. Justification/Need must include documentation of the name of at least one other qualifying Waiver service currently authorized under the Waiver and a description of the modification being requested. <ul style="list-style-type: none"> <li>Dates of service authorized cannot crossover the DMAS POC year.</li> </ul> <b>MFP Waiver:</b> Justification/Need must include documentation for the description of the item, cost of materials, labor and must describe the direct medical and/ or remedial benefit to the individual.  <b>Tech Waiver:</b> Justification/Need must include documentation for the description of the item, cost of materials, labor and must describe the direct medical benefit to the individual.	MFP, DD, Tech Waiver
99199 U4	<b>Environmental Modifications – Maintenance: Used when request is for maintenance to a previous approved and purchased item.</b> <ul style="list-style-type: none"> <li>Service must be approved on the DMAS DD POC.</li> <li>See code S5165 in this table.</li> </ul>	MFP, DD, TECH
S5185	<b>PERS and Medication Monitoring:</b> See Code H2021TE and H2021TD in this table.	DD, EDCD
S9125TE	<b>Respite Services-LPN:</b> See code S9125TD in this table.	EDCD, TECH
S9125 TD	<b>Respite Services- RN</b>	TECH
T1002	<b>Private Duty/Skilled Nursing-RN:</b>  <b>DD Waiver:</b> <ul style="list-style-type: none"> <li>Service must be approved on DMAS DD POC</li> <li>Service may be authorized for up to 6 months per request in accordance with the date range covered by the CMS 485 and DMAS DD POC.</li> <li>Justification/Need must include date of physician's signature on the CMS 485 and the effective start of care date of the physician's order/CMS 485.</li> </ul>	DD
T1003	<b>Private Duty/Skilled Nursing-LPN:</b> See Code T1002 in this table.	DD



## Community Based Care Request for Services Form

National Code /Modifier	Service Category/Description	Waiver
T1005	<p><b>Agency Respite Care/Services:</b></p> <p><b>DD Waiver:</b> Justification/Need must include the name of attendant and relationship to the Member.</p> <ul style="list-style-type: none"> <li>Service must be approved on DMAS DD POC.</li> </ul> <p><u>For readmissions after discharge or transfer to a new provider:</u> A new assessment (DMAS 99) must be included in the documentation. Justification/Need must include documentation of the name of the <b>unpaid</b> PCG and the name of the paid attendant.</p> <p><b>EDCD Waiver:</b> Justification/Need must include documentation of the name of the unpaid PCG, the name of the individual directing the care, name of the emergency back-up person and where the care is provided.</p>	DD, EDCD
T1016	<p><b>Case Management:</b> Justification/Need must include documentation of what other services are being provided. For ECM, statement with goals and expected timeframes for completion must be included and the date the Provider and Member signed the plan of care must be stated.</p>	ECM
T1019	<p><b>Personal Care:</b> <b>EDCD Waiver</b> Justification/Need must include documentation of the Member's mental/cognitive status, and name of emergency backup person. The Member's LOC from the DMAS 97A/B ( if LOC C, the skilled nursing need must be stated) the type of services needed and the time of day it is provided, the total number of weekly hours requested where the services are performed and the first day the aide provided hands on care. The number of hours of Supervision, documentation of the Member's mental/cognitive status, ability to use the phone, no one present in the home to call for help and why it is needed. Who is with the Member at all times when the aide is not present?</p> <p><b>DD Waiver:</b> Justification/Need must include documentation of name of the attendant and relationship to the Member.</p> <ul style="list-style-type: none"> <li>Service must be approved on DMAS DD POC.</li> </ul> <p><u>For readmissions post discharge or transfer to a new Provider:</u> A new assessment (DMAS 99) must be included in the documentation. If there is an increase or decrease in the amount of hours from the previous authorization/Provider, information from a new Plan of Care (DMAS 97 A/B) and justification for the change in hours is required for review.</p> <p><b>NOTE: Training is not PC services.</b></p>	DD, EDCD, EPSDT PC/AC



## Community Based Care Request for Services Form

National Code /Modifier	Service Category/Description	Waiver
T1999	<p><b>Assistive Technology Rehabilitation/ Off shelf item:</b>  <b>DD Waiver:</b>  <b>Any request, change, increase, decrease and /or update must be pre-approved by DMAS on the POC before Service Authorization can occur.</b>            Justification/Need must include documentation of the name of the item and total cost, which is not carried over from one POC year to another POC year.</p> <ul style="list-style-type: none"> <li>• Date of service authorized cannot crossover the DMAS DD POC year.</li> </ul> <p><b>Tech Waiver:</b>            Justification/Need must include documentation of the name of at least one other qualifying Waiver service. Cost cannot be carried over from one calendar year to another calendar year.</p> <p><b>MFP and Tech Waiver:</b>            Justification/Need must include documentation item must be from a qualified professional and include the description of the item, cost of materials, labor and must provide direct medical benefit to the individual.</p>	MFP, DD, Tech Waiver
T1999 U5	<p><b>Assistive Technology Maintenance Cost: Used when request is for maintenance to a previous approved and purchased item.</b>            See code T1999 in this table.</p>	DD, Tech Waiver, MFP
H2015	<p><b>Transition Coordination.</b> To qualify under MFP, individual must be a resident of a NF or Long-Stay Hospital and must be enrolled in MFP. The maximum authorization for Transition Coordination while in a facility is 60 days under 0909 MFP service type. Once the individual has moved to the community, Transition Coordination may be requested /approved for a maximum of 12 additional months under the EDCD waiver (0900). For MFP enrollment, certify on the request the individual meets all MFP requirements.</p> <p><b>EDCD Waiver:</b> Must be enrolled in EDCD Waiver            The authorized begin date of H2015 must not be prior to the begin date of EDCD enrollment, when this service is being requested under EDCD, service type 0900 (Member discharged from a NF or Long-Stay Hospital). H2015 may have already been authorized under MFP, service type 0909 while in the facility; this does not affect the authorization through EDCD.</p>	MFP, EDCD
H2015	<p><b>Transition Coordination.</b> To qualify under MFP, individual must be a resident of a NF or Long-Stay Hospital and must be enrolled in MFP. The maximum authorization for Transition Coordination while in a facility is 60 days under 0909 MFP service type. Once the individual has moved to the community, Transition Coordination may be requested /approved for a maximum of 12 additional months under the EDCD waiver (0900). For MFP enrollment, certify on the request the individual meets all MFP requirements.</p> <p><b>EDCD Waiver:</b> Must be enrolled in EDCD Waiver            The authorized begin date of H2015 must not be prior to the begin date of EDCD enrollment, when this service is being requested under EDCD, service type 0900 (Member discharged from a NF or Long-Stay Hospital). H2015 may have already been authorized under MFP, service type 0909 while in the facility; this does not affect the authorization through EDCD.</p>	MFP, EDCD



## Community Based Care Request for Services Form

National Code /Modifier	Service Category/Description	Waiver
T2038	<b>Transition Services.</b> The Transition Coordinator or Case Manager must submit the request for Transition Services. Prior to and after discharge from the facility, <b>Transition Services may be requested for individuals transitioning into EDCD Waiver.</b> DMAS processes DD Waiver requests for Transition Services prior to and after discharge. Requests for Transition Services must be submitted within 30 days of the NF/Long-Stay Hospital discharge date. <b>Member must be enrolled in MFP or the specific Waiver and have been a resident of an NF for 6 months prior to Waiver enrollment.</b>	EDCD, DD, MFP
S9123	<b>RN Nursing Services and Assessment</b>	EPSDT PDN
S9124	<b>LPN Nursing Services</b>	EPSDT PDN
G0162	<b>RN Congregate Nursing Services</b>	EPSDT PDN
G0163	<b>LPN Congregate Nursing Services</b>	EPSDT PDN

15. **Procedure Code:** Provide the HCPCS/CPT/Revenue/National procedure code (For example, T1019, S5135, etc.)
16. **Narrative Description:** Provide the HCPCS/CPT/Revenue/National procedure code description. (For example, Personal Care, Companion Care, etc.)
17. **Modifiers (if applicable):** Enter up to 4 modifiers as applicable. This applies only to specific Procedure Codes. See chart above. Example: Pre-Vocational Services, High Intensity, U1 is the modifier.
18. **Units/Hours Requested:** Based on physician's orders or Plan of Care provide the number of units/hours requested. Knowledge of DMAS criteria will be extremely helpful. How much of the service is being requested? Example: S5126, CD Personal Care, 30 hours/ week. The 30 hours is the Units/hours requested.
19. **Actual Cost per Unit (Assistive Technology or Environmental Mods Only):** Enter information in this column for codes identified as needing a cost per unit. For AT, actual cost reflects wholesale cost.
20. **Frequency:** Enter the frequency of the visits/service from the physician's order or Plan of Care. (day, week, biweekly {every other week}, month, year)
21. **Total Dollars Requested (Assistive Technology and Environmental Mods, Only):** If applicable, enter the dollar amount requested for items listed. All AT/EM codes combined cannot exceed \$5,000.00 in a calendar year. For AT, Wholesale cost will be reimbursed at the cost x 30%.
22. **Dates of Service:** Indicate the planned service dates using the MM/DD/YYYY format. The from and thru date must be completed even if they are the same date.
23. **Contact Name:** Enter the name of the person to contact if there are any questions regarding this fax form.
24. **Contact Phone Number:** Enter the phone number with area code of the Provider contact name.



### Community Based Care Request for Services Form

25. **Contact Fax Number:** Enter the fax number with the area code to respond if there is a denial/reject, a need to request additional information, insufficient (demographic) information, or to send a General Provider Letter via fax.

*Note: Incomplete data may result in the request being rejected or denied; therefore, it is very important that this form be completed as thoroughly as possible with the pertinent information.*

*The purpose of Service Authorization is to validate that the service being requested is medically necessary and meets DMAS criteria for reimbursement. Service Authorization does not automatically guarantee payment for the service; payment is contingent upon passing all edits contained within the claims payment process, the Member's continued Medicaid eligibility, and the ongoing medical necessity for the service being provided.*

*There are no automatic renewals of services and you must request service authorization before the current authorization ends to avoid any breaks in services.*